

NOV FEB 25 1941

Registration District No. 2

Primary Registration District No. 205

Registrar's No. 4

1. PLACE OF DEATH:

(a) County Andrew,  
(b) City or town Savannah,  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Dr. Nichols Sanitorium  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 8 days,  
(Specify whether  
In this community 8 days,  
years, months or days)

3. (a) PRINT FULL NAME Alice C. Stayer,

3. (b) If veteran, name war None, 3. (c) Social Security No. Unk.

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced / /

6. (b) Name of husband or wife Unknown, 6. (c) Age of husband or wife if alive            years

7. Birth date of deceased Nov. 11th. 1872  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>68</u>	<u>1</u>	<u>23</u>	hr. <u>          </u> min. <u>          </u>

9. Birthplace Columbia City, / Indiana,  
(City, town, or county) (State or foreign country)

10. Usual occupation Unknown,

11. Industry or business           

12. Name Absolon Stiver,

13. Birthplace Unknown,  
(City, town, or county) (State or foreign country)

14. Maiden name Sarah McPherson,

15. Birthplace Unknown,  
(City, town, or county) (State or foreign country)

16. (a) Informant Holland & Bohring Funeral  
(b) Address Havre, Montana,

17. (a) removal (b) Date thereof 1/10/41  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Havre, Montana,

18. (a) Signature of funeral director Franz A. Bohring  
(b) Address Savannah, Mo.

19. (a) Jan. 9 - 41 (b) Mrs. Jennie Rash  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MONTANA (b) County Hill  
(c) City or town HAVRE  
(If outside city or town limit write "RURAL")  
(d) Street No.             
(If rural, give location)  
(e) If foreign born, how long in U. S. A. 2 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JAN. day 9  
year 1941 hour 3 minute 45 P.M.

21. I hereby certify that I attended the deceased from JAN. 1, 1941, to JAN. 9, 1941 that I last saw her alive on JAN. 9 - 41 and that death occurred on the date and hour stated above.

Immediate cause of death CARCINOMA (BREAST) LEFT

Due to EMBOLISM (PULMONARY)

Due to CARCINOMA BREAST  
Other conditions CARCINOMA BREAST  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations             
Of autopsy no autopsy

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify)             
(b) Date of occurrence             
(c) Where did injury occur? (City or town) (County) (State)             
(d) Did injury occur in or about home, on farm, in industrial place, in public place?           

23. Signature Floyd H. Bennett (M. D. or other) M.D.  
Address            Date signed 1-9-41

Duration

8 years

3 hours

8 years

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1111

Andrew Savannah

Dr. Nichols Sanitorium  
8 days

8 days

Alice C. Stayer

unk.

Female White

Unknown  
Nov. 11th. 1922

23 1 23

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by \_\_\_\_\_ 1-9-4

Registered Apprentice No. \_\_\_\_\_

working under my personal supervision.

Signed \_\_\_\_\_

Havee Louana  
Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 15-72

Registration District No. 2

Primary Registration District No. 205

Registrar's No.

1. PLACE OF DEATH:

(a) County Andrew  
(b) City or town Savannah  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether  
In this community \_\_\_\_\_  
years, months or days)

3. (a) PRINT FULL NAME Alice C. Stayer

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex 7 5. Color or race W 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Samuel Stayer 6. (c) Age of husband, or wife, if alive 68 years

7. Birth date of deceased \_\_\_\_\_ (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>68</u>	<u>1</u>	<u>28</u>	hr _____ min _____

9. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) Jan. 9 - 1941 (b) Mrs. Jennie Rash  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_  
(If outside city or town limits write "RURAL")  
(d) Street No. \_\_\_\_\_  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

20. DATE OF DEATH Month Jan day 9  
year 1941 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury \_\_\_\_\_

23. Signature Floyd H. Spencer (M. D. or other) \_\_\_\_\_  
Address Savannah Mo Date signed \_\_\_\_\_

Duration \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

S-1572